Full Recommendations of the NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes

Chapter 3: Increasing Options for Individuals with Disabilities

Recommendation 3.1: Pilot Program (PRIORITY RECOMMENDATION)

The North Carolina Department of Health and Human Services (DHHS) should develop a pilot program to evaluate the costs, quality, consumer satisfaction, and patient outcomes of a program that supports individuals who would otherwise be in an adult or family care home and who want to move into independent supported housing. As part of this, DHHS should:

a) **Submit a Medicaid 1915(i) state plan amendment or 1915(c) HCBS waiver to support individuals living in adult or family care homes (ACH) for 90 or more days who would like to move back to more independent living arrangements. The 1915(i) state plan amendment should be modeled after the state's Money Follows the Person[a] initiative for people in nursing facilities. The Medicaid 1915(i) state plan amendment should provide home and community-based services, including, but not limited to, personal care services, adult day care, and case management, and should pay for reasonable one-time transitional costs, including but not limited to security deposits, first month rent, or home modification.**

b) **DHHS should develop a process to evaluate people living in ACHs to determine whether people can appropriately live independently in the community with services and supports, and should provide counseling and transition services to appropriate individuals who want to move to more independent living arrangements.**

c) **The pilot program should initially be limited to 1,000 individuals who want to, and can appropriately, move to more independent living arrangements with services and supports. Individuals who move out of an ACH should continue to receive the same level of State-County Special Assistance (SA) payment in the community as they were receiving in the ACH. These SA in-home payments should be exempt from the SA in-home limits established as part of Session Law 2007-323.**

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a Money Follows the Person is a nursing facility transition program that identifies consumers in institutions who wish to transition to the community and allows Medicaid funds budgeted for institutional services to be spent on home and community services when individuals move to the community. Centers for Medicare & Medicaid Services. *Real Choice Systems Change Grant Program: Money Follows the Person Initiatives.* US Department of Health and Human Services; 2006.

d) DHHS should conduct an evaluation to examine costs, quality, individual satisfaction, and patient outcomes of this demonstration in supporting people with disabilities and the frail elderly who would otherwise need ACH level of care to live more independently in the community. The results of the evaluation should be shared with the appropriate legislative committees that address the needs of older adults and of people with mental illness, intellectual and developmental disabilities, and addiction disorders no later than fall 2013 and annually thereafter. If the program is found to be successful, the North Carolina General Assembly should implement the program statewide both for individuals who are residing in ACHs and for those who have not yet entered an ACH but who meet the level of need criteria.

e) The North Carolina General Assembly should appropriate $100,000 non-recurring funds in state fiscal years 2012-2014 to the North Carolina Department of Health and Human Services to provide technical assistance to help interested ACHs create financially viable models that support people to live more independently in the community, such as, but not limited to, multi-unit supported housing, recovery-based scattered housing, transitional housing, and adult day care. DHHS should strive to work with rural, urban, large, and small ACH facilities.

f) DHHS should continue its work to remove statutory and regulatory barriers to independent living options for people with disabilities who receive services in the community.

Recommendation 3.2: Increase Funding for Housing for Individuals with Disabilities

a) To help individuals with disabilities better afford housing, the North Carolina General Assembly should appropriate $10 million in additional recurring funding beginning in state fiscal year 2011 to the North Carolina Housing Finance Agency to increase funding to the North Carolina Housing Trust Fund. A significant portion of the funding should be targeted for housing for individuals with disabilities.

b) DHHS should work with the Housing Finance Agency to explore options to create transitional housing for people who need short-term stabilization options to help them make a transition to more independent living in the community.

Recommendation 3.3: Create an Inventory of Community Housing Options for Individuals with Disabilities

a) As part of the local management entity's (LME) performance contract with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), DMHDDSAS should require LMEs, working with DMHDDSAS, the Division of Health Services Regulation, and the North Carolina Department of Health and Human Services housing specialists, to develop a real-time inventory of community housing options, including 122C therapeutic mental health homes, substance abuse and developmental disability group homes, adult and family care homes, supported living arrangements, and independent living options, and make this inventory available to families. The lists should be collected and aggregated at the state level and should be made available both online and in person through the LMEs.

Chapter 4: Restructuring the Current System

Recommendation 4.1: Requiring Standardized Preadmission Screening, Level of Services, and Assessment Instruments in Adult and Family Care Homes and 122C Facilities (PRIORITY RECOMMENDATION)

a) The North Carolina General Assembly should direct the Department of Health and Human Services (DHHS) to require adult and family care homes (ACH), and 122C mental health, developmental disability, and substance abuse group homes (122C) to use standardized preadmission screenings, level of services determinations, assessments and care planning instruments. DHHS can designate different instruments for different types of licensed facilities, regardless of payment source.

b) For adult and family care homes:

1) The screening, assessment and care planning process should be redesigned:

i. The level of services preadmission screening tool should be revised to replace the current FL-2. The tool should be automated and should capture information on diagnosis (including, but not limited

to, physical condition, mental health, substance use disorders, cognitive impairments, intellectual and other disabilities, and other health conditions), functional capacity with activities of daily living and instrumental activities of daily living, need for supervision and medication supervision, and conditions that could pose a threat to the health or safety of self or others.

ii. **Individuals who have been identified as having a mental health problem, substance use disorder, cognitive impairment, or intellectual and other disability as part of the level of services preadmission screen should receive a more complete independent screening assessment by a trained mental health, substance abuse, or developmental disability professional. DHHS should develop a system to ensure that individuals who cannot be appropriately served in an adult care home are provided other appropriate housing and/or treatment options, and that all individuals with mental health problems, intellectual and developmental disabilities, or addiction disorders are provided appropriate supports and services designed to maximize their independence.**

iii. **Once a resident is admitted, facilities should be required to administer standardized care planning assessment instruments (as identified by DHHS) to obtain more detailed information that can be used in developing a person-centered care plan.**

2) **DHHS should develop appropriate time standards to conduct the screening and assessment to ensure that admissions to ACHs are not being unreasonably delayed by this two-level screening process.**

3) **Existing residents of adult and family care homes should all receive screening, assessment, and care planning following this new process within one year of implementation of the new process.**

a) **The instruments may be different for different types of facilities, but the data collected in the instruments should be consistent across types of settings and should be automated. The data collected as part of the level of services preadmission screening and assessment instruments should be consistent with existing data collection efforts. Data collected should include demographic characteristics; diagnoses; and physical health, mental health, substance use, and cognitive and behavioral functioning of the different populations housed in ACHs and 122Cs, regardless of payer source. This information should be available and accessible to DHHS as well as shared with other state and local entities, including but not limited to the Division of Aging and Adult Services, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Health Service Regulation, Local Management**

Entities, the Department of Social Services, and local Divisions of Social Services.

b) **The North Carolina General Assembly should appropriate $900,000 in recurring funds in state fiscal year (SFY) 2012, $228,000 in non-recurring funds in SFY 2012, and $205,000 in non-recurring funds in SFY 2013[b] to DHHS to support the implementation of the automated level of services preadmission screen, assessment instrument, and prior approval for people seeking admission to ACH and 122C facilities.**

c) **DHHS should report annually to appropriate legislative committees that address the needs of older adults or of people with mental illness, intellectual and developmental disabilities, or addiction disorders on the data gathered about needs identified in the level I and level II screenings, placement of individuals with disabilities, and outcomes for individuals with disabilities living in ACHs.**

Recommendation 4.2: Local Management Entity Outreach and Education for Adult and Family Care Home Staff

a) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should require local management entities (LME) to hold an informational forum at least twice a year for staff of adult and family care homes (ACH) and geriatric adult specialty teams (GASTs). The LME forum should help ACH and GAST staff understand the LME's purpose and function, as well as the resources and services accessible through the LME, including crisis services. In addition, the forum should provide the opportunity for LME staff to learn about the types of clients served in community facilities and the concerns of community facilities. These forums should facilitate linkages between adult care homes, family care homes, LMEs, mobile crisis teams, geriatric adult specialty teams, and other appropriate community agencies to ensure that the physical health, mental health, substance abuse, and cognitive and behavioral needs of the clients with behavioral problems can be appropriately addressed.**

b) **The Division of Health Service Regulation should encourage all supervisors and managers in adult care homes and family care homes to attend at least one LME forum.**

b Cost estimates from the Division of Medical Assistance, North Carolina Department of Health and Human Services. Walton, J. Waiver Development Chief, Division of Medical Assistance, North Carolina Department of Health & Human Services. Written (email) communication December 17, 2010.

Recommendation 4.3: Case-Mix Adjusted Payments

The North Carolina Department of Health and Human Services should use the information obtained from validated assessment instruments to develop case-mix adjusted payments for adult and family care homes and 122C facilities. Payments should be adjusted on the basis of the acuity of a person's needs for services and supports, and this basis should include, but not be limited to, the following:

a) **The person's underlying physical health, mental health, intellectual and other developmental disability, substance use disorder, or cognitive impairment.**

b) **The level of a person's functional abilities including their ability to communicate, perform activities of daily living and instrumental activities of daily living, and their need for supervision and medication administration.**

c) **The extent to which a person manifests inappropriate verbal, sexual, or physical behaviors that can pose a threat to self or others.**

Chapter 5: Training Requirements for Adult Care Homes and 122C Facilities

Recommendation 5.1: Use Geriatric/Adult Mental Health Specialty Teams to Provide Training in all ACHs

a) **The North Carolina General Assembly should enact legislation to require all adult and family care homes (ACH) to receive geriatric/adult mental health specialty team (GAST) training at least three times per year. The training should be tailored to the needs of the specific ACH but should, at a minimum, cover person-centered thinking and de-escalation skills. Staff on all three shifts (including supervisors, administrators, personal care assistants, medication aides, and any other workers who have direct hands-on contact with residents) should receive this training at least once per year.**

b) **The North Carolina Department of Health and Human Services should evaluate and report back to appropriate legislative committees that address the needs of older adults or people with mental illness, intellectual and developmental disabilities, or addiction disorders by fall 2012 information on whether there are enough GAST resources to meet the new training requirements and whether there are sufficient mobile crisis teams and START crisis teams to meet the needs of ACHs in the event of behavioral health crises.**

Recommendation 5.2: Require Adult and Family Care Home Staff to Be Trained and to Exhibit Competency in Person-Centered Thinking and Crisis Prevention

The North Carolina General Assembly should require all adult and family care home direct care workers, personal care aides, medication aides, and supervisors to be trained and to have passed the competency exam for state-approved crisis intervention training by June 2013.

Recommendation 5.3: Pilot New Behavioral Health Training and Competency Examination Requirements for New Direct Care Workers

a) The North Carolina Division of Health Service Regulation (DHSR), in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) and the Division of Medical Assistance, should develop a standardized curriculum and competency test for new direct care workers as part of the federal Personal and Home Care Aide State Training Program (PHCAST) grant. The core training should include, but not be limited to, the following:

1) Knowledge and understanding of the people being served, including the impact of aging on different populations.

2) Recognizing and interpreting human behavior.

3) Recognizing the effect of internal and external stressors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.

4) Strategies for building positive relationships with persons with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders and for recognizing cultural, environmental, and organizational factors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.

5) Recognizing the importance of and assisting in the person's involvement in making decisions about his or her life.

6) Skills in assessing individual risk for escalating behavior.

7) **Communication strategies for defusing and de-escalating potentially dangerous behaviors.**

8) **Positive behavioral supports providing means for people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders to choose activities that directly oppose or replace behaviors that are unsafe.**

9) **Information on alternatives to the use of restrictive interventions.**

10) **Guidelines on when to intervene (understanding imminent danger to self and others).**

11) **Emphasis on safety and respect for the rights and dignity of all persons involved, including least restrictive interventions and incremental steps in an intervention.**

12) **Knowledge of prohibited procedures, including but not limited to abuse, neglect, and exploitation.**

13) **Debriefing strategies, including their importance and purpose, particularly after resident deaths.**

14) **Documentation methods/procedures.**

The competency test developed should include both written and skills-based evaluation of training related to working with individuals with disabilities.

b) **To encourage retention of qualified staff, staff who undergo additional training and who demonstrate additional competencies should be rewarded with higher salaries.**

c) **The DHSR should evaluate and make recommendations about whether this training should be mandatory for all direct care workers. DHSR should report its findings to the appropriate legislative committees that address the needs of older adults or people with mental illness, intellectual and developmental disabilities, or addiction disorders by the end of the three-year PHCAST pilot.**